Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
South Shore Surgicenter

Respondent Name
Liberty Mutual Corp

MFDR Tracking Number
M4-13-3093-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient's permanent suture poked through skin, and it has trigged a granuloma which hasn't healed. Open wound possibly getting infected as well."

Amount in Dispute: $18,309.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have no record of a request for preauthorization of ….. surgery on 8/21/12. The charges remain denied."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2012	Outpatient Surgical Services	$18,309.99	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - 18 – Duplicate claim/service

Issues

1. Did the requestor comply with Division rules in regards to prior authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 97 – "Pre-authorization was required, but not requested for this service per DWC rule 134.600." "28 Texas Labor Code §134.600(p)(2) states in pertinent part, "Non-emergency health care requiring preauthorization includes (2) outpatient surgical or ambulatory surgical services …" Review of the submitted documentation finds;

    a. Hand History & Physical dated August 15, 2012

    28 Texas Administrative Code §134.600(h)(i) states, (i) The insurance carrier shall contact the requestor or injured employee within the following timeframes by telephone, facsimile, or electronic transmission with the decision to approve the request; issue an adverse determination on a request; or deny a request under subsection (g) of this section because of an unrelated injury or diagnoses as follows: (1) three working days of receipt of a request for preauthorization… The services in dispute were performed August 21, 2012, six days after the evaluation. The health care provider would have had ample time to request and receive prior authorization. Therefore review of the submitted documentation finds the health care provider did not comply with Division rules. The carrier's denial is supported.
2. Requirements of 134.600 not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 12, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.